Forensic Mental Health: From Assessment to Recovery

The Perils of Disclosure: Writing the Forensic Report

Chapter 4

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"Between my finger and my thumb

The squat pen rests; snug as a gun"

(Seamus Heaney)

Sean Kaliski

The assumption that the written report must be the culmination of the forensic assessment, was not, and still not always true. From the 19th century to perhaps the mid 20th century experts usually conveyed their findings by testifying in court (Weiss et al., 2011). Their rationale was two-fold. Firstly, they feared that a written report would give the opposing counsel advance notice for cross-examination, and secondly, if their oral testimony was not needed then writing a report was a waste of time. Nowadays, retaining counsel may insist on an initial verbal report in case the assessment does not support their case (Wettstein, 2010, Giorgi-Guarnieri et al., 2002). Nevertheless, experts should be aware that even if they did not submit a report the court can issue a subpoena for their clinical notes that could include any preliminary reports they may have drafted.

Reports should be compiled to provide (Weiss et al., 2011, Ramshaw et al., 2022):

- A narrative of relevant information about the examinee.
- An analysis and opinion that can be used to deliberate on the legal issues.
- Issues that may be important for expert testimony.
- Recommendations, which could include treatment, rehabilitation, risk management or any other pertinent intervention.
- An indication of good clinical practice that not only verifies the examiner's credentials but also contributes to the general standing of forensic mental health.

Preparation

No report should be based solely on an interview. Examinees rarely provide enough important information, and it can be rather unpleasant to discover this while being cross-examined in a hearing. Conversely, even when a mountain of information from all possible sources is available there is always a niggle that somehow a vital piece may be missing.

While embarking on the assessment, and, of course, before writing the report it is vital to determine what the purpose of it is, and to whom it will be submitted (Gunn et al., 2014). The expert should be leery of referral notes that just ask vaguely for a forensic assessment without specifying the reasons for the referral or providing supporting documentation.

The array of information should, like Gaul, be divided into 3 parts:

- That which preceded the assessment, such as a police docket or description of the circumstances that led to it. These sources should have been perused before accepting the brief to ensure that the examiner is not being asked to perform an assessment that is beyond her scope of practice or expertise (Wills, 2011).
- That elicited from the clinical evaluation.
- That provided afterwards, such as results of tests and investigations, provision of collateral information and court rulings etc.

Somehow pertinent information must be extracted from this morass of data and organised into a coherent narrative.

Disclosure- Choosing between too much and too little.

Assessments generate heaps of data, all of which contribute to understanding the examinee and the contexts within which the index (legal) issues occurred. Winnowing the relevant and important information from the chaff of nice-to-know details requires experience and, at least initially, mentoring from more battle-hardened colleagues. The report should be a distillation of the essential findings[1]. But what is essential? As Martinez and Candilis (2011) insist:

1 This is seemingly a paradox. After all, if only a relatively small subset of information is to be communicated by the report why attempt to extract as much detail about the examinee as possible? The examiner must appreciate that if the report is disputed a hearing will most likely be held, in which counsel can ask anything they please about the examinee. Sometimes the disputing party, which can also be the court, can go *off piste* due to unexpected evidence or new line of inquiry. Of course, if the examiner cannot provide basic information, which may have little to do with the relevant legal issues, it can create the impression that the assessment was not thorough and its conclusions therefore spurious.

"Forensic reports, then, are a form of rhetoric, a tool for argument and persuasion. As such, they involve large and small decisions that determine what information is included or excluded, what data are stressed or minimised, what descriptions are informative or prejudicial." (p.62)

Suppose an accused, who is undergoing an assessment following a charge of housebreaking, confesses to experiencing violent fantasies and urges. Or during a child custody evaluation the mother relates how she used to have sex with her ex-husband in his office. Should these bits be included in the report? Information should undergo a triage, into 3 heaps; must, could and must not be included.

1. *Information that must be disclosed.*
    a. The examiner's professional qualifications and expertise. Occasionally this may require submitting a brief CV. When the examiner works for an organization, such as a forensic hospital, the organization's details usually are best presented in the report's letterhead.
    b. Examinee's name and demographic details
    c. The source of the referral.
    d. How the assessment was conducted and the methods used (Almazrouei et al., 2019).
    e. The legal issues that were addressed. In criminal cases this usually is in accordance with a court order, either under specific sections of legislation or a court order. In civil cases these must have been clearly stated by the referring agent, even if the brief is broad.
    f. Whether informed consent was given by the examinee, or was not necessary[2]
    g. Any conflicts of interest. Examples include any pre-existing relationships with the examinee or organisations that could have influenced the conduct of the evaluation. Conflict of interest exists when there is the appearance of inappropriateness, even if the examiner's conduct has been exemplary. If the assessment was completed despite the appearance of a conflict of interest the examiner must state how she ethically dealt with it.
    h. How the examination was conducted, mostly to confirm that the expert(s) followed the standard operating procedures (Almazrouei et al., 2019).
    i. Collateral sources of information.
    j. Results from tests and special investigations
2. *Information that requires caution and discretion.*
    Even though all forensic assessments are conducted either under cover of a court order or informed consent the examiner has an ethical obligation to balance the examinee's right to privacy with the need to include potentially harmful (or gratuitous but prejudicial) information (Martinez and Candilis, 2011).
    a. *<u>The examinee's account</u>:* Not infrequently reports contain the examinee's verbatim (and sometimes lengthy) account. Apart from testing the recipients' attention span there are many compelling reasons to be cautious.
        i. In criminal cases the accused's account should not be provided unless it supports the evaluation's findings, as provided by section 79(7) of the CPA. Such accounts invariably appear to be confessions and may cause problems if the accused subsequently decides to provide the court with a different version. It is arguably far better to comment on the quality of the accused's account, which can range from a refusal to provide information, amnesia for the alleged offence, a psychotic version, an inconsistent explanation

2 Two obvious instances when informed consent is not provided are, firstly, when the court has ordered the evaluation, and secondly when during the evaluation it becomes evident that the examinee lacks competence.

to an exculpatory account[3].

ii. Civil cases generally rely on the examinee's narrative, which should flow chronologically from when she was well to her current mental state and functioning. Not only does this provide a contrast between her premorbid and current states but also can make possible direct links to salient events, which may be important for apportioning blame and determining compensations. The eventual readers of the report do not want to be confronted with a simulacrum of 'War and Peace" loaded with irrelevant and tedious details, or gratuitous harmful information.

b. *The use of collateral sources of information:* Documents, interviews with third parties (TP), data available on the internet, school and police records always help to bolster the accuracy of the report, hopefully by triangulation of the sources. But there are caveats.

i. Third parties, who usually are close to the examinee, may be shocked, traumatised (and may have PTSD), grief-stricken or guilt-ridden and accordingly can be unreliable (Goldenson et al., 2023). Occasionally the TP may assume that the examiner's empathy during the interview has created a therapeutic alliance between them and may expect to be counselled or provided with feedback[4].

ii. Also, the TP may collude with the examinee. Interviews with many others can alleviate this, although the examiner may have to record that the information obtained contains inconsistencies.

iii. Many TPs may have a poor memory of the periods under question, especially if the evaluation occurs many years after the disputed events occured.

iv. The collateral information may be incorrect. Examiners can be tempted to insist that they have verified the data, which only a court or a hearing can do. If the information ultimately is found to be false and the examiner has insisted otherwise the validity of the entire assessment will be questioned.

v. Conversely the information can be reliable but also harmful. This could involve others who have no part in the current proceedings, but whose behaviour may have influenced the examinee's mental state. Examples include allegations that a family member sexually abused her during childhood or that she falsely believed that her mother was her sister and that her grandmother was her mother. There are many such variations, and the dilemma is firstly to determine whether inclusion of the information is crucial, and if so, how to communicate it in a constructive therapeutic way. If this cannot be done, then the information may have to be excluded or indicated in a vague but safe language.

vi. An unresolved issue is whether collateral information obtained from a telephone call is as reliable as an in-person interview. In the former, the TP may be in the company of others who may intimidate or inhibit her responses, and where it is not possible to note non-verbal cues (Goldenson et al., 2023).

vii. In my experience TPs have never provided informed consent and are not informed about the limits of confidentiality. As noted above, TPs may unwittingly provide harmful information under the assumption that the examiner's empathy protects them.

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3 When the accused was psychotic some indication of her symptoms, especially if directly related to the alleged offence, should be offered. In cases in which the accused claims to have amnesia discretion should be used. Usually, it is sufficient merely to comment on the quality of the account beforehand (retrograde amnesia) and when normal memory functioning resumed.

4 Examiners should be aware of creating the impression that a therapeutic relationship arises during the interview and should gently inform the TP of this. But if the TP seems to need a mental health intervention the examiner can refer her to an appropriate mental health practitioner.

viii. Courts in the USA have provided differing stances regarding whether collateral information, especially from interviews with TPs, should be regarded as hearsay, and therefore not admissible as evidence (Heilbrun et al., 2015). In SA courts often question the source of the information and how it was obtained. If another professional, such as a social worker, obtained the information, the courts sometimes insist on cross-examining that professional. TPs can be called to testify, where the veracity of their information can be tested.

c. *Documentation of malingering*: Although malingering is not a medical diagnosis DSM-5 defines it as a category in which there is "the intentional production of false or grossly exaggerated physical or psychologic symptoms, motivated by external incentives" (APA, 2013). It is a pejorative term that forecloses the possibility of genuine illness. The outcomes of those dismissed as malingerers are generally poor, even after the settlement of their legal cases, especially if they have had symptoms for long periods (Gelauff and Stone, 2016). An unknown number eventually are diagnosed with genuine disorders. Consequently, it is advisable not to use the term in a report. The writer can state that no cause of the examinee's symptoms could be ascertained. Nevertheless, in cases where the examinee has certainly been malingering to escape conviction for a serious offence it may be necessary to characterise his presentation more strongly.

3. *Information that must not be included.*

   a. *Derogatory and snide remarks about anyone involved, including other experts*. Resist the temptation to heap scorn on other's blatant unethical or dishonest behaviour because it will damage the professionalism (and possibly credibility) of the report (Resnick and Soliman, 2011, Wettstein, 2010).

   b. *Avoid using information of which the examinee is unaware*. Occasionally it may be possible to share the information with the examinee beforehand. Sometimes the source of the information will request that it remains confidential. This could be a tricky dilemma which will require discussion with the retaining counsel or senior colleagues.

   c. *Avoid including anything that cannot be defended under cross-examination* (Ramshaw et al., 2022). Obviously, this includes groundless speculations as well as plausible assumptions that are based on skimpy data.

Diagnoses, Opinions and Recommendations

The (hopefully cogent) forensic narrative always demands an exegesis by providing diagnoses (or not), explanations of how the data relate to the forensic inquiry and recommendations that could be considered.

a. *The paradoxical use of diagnoses*. The nexus of the forensic report is the presence or absence of a diagnosis (or diagnoses). Some authorities do assert that functional impairments can occur without the presence of a disorder (Mokgoro et al., 2004), but, as a rule, a diagnosis that conforms to the criteria as set out in DSM 5 (or ICD-11) is essential[5]. Unfortunately, DSM 5 contains the caveat that "..the use of DSM 5 should be informed by an awareness of the risks and limitations of its use in forensic set-

5 There are many labels, such as "Battered Woman's Syndrome" that have popular currency but lack scientific approval. A notable exception is psychopathy, for which there is voluminous evidence but is represented imperfectly in DSM as Antisocial Personality Disorder".

tings" p.25 (APA, 2013). Frances and Halon (2013) point out that psychiatric language does "poorly in nitpicking courts" and that psychiatric diagnoses depend on subjective judgements and therefore are fallible. Because stakes in forensic settings are high, unlike in ordinary clinical practice, differential diagnoses should be offered if there is no overwhelming evidence for a definitive diagnosis.

b. *An exposition must follow in which important aspects of the report are used to substantiate the diagnosis, decide on the severity of impairment and its relevance to the forensic issue*.
    a. Commonly this section is contentious because it relies on subjective judgements and allows the examiner to select data that support her assessment (Frances and Halon, 2013). Crucial distinctions between facts, assumed facts and opinion must be clearly stated.
    b. Inexperienced examiners, who can be dogmatic about their conclusions, are commonly bemused when summonsed to a hearing to explain how they reached their conclusions, and why certain data were not used. It is advisable to be tentative, or highlight, when the information is either ambiguous or contradictory (Gunn et al., 2014, Resnick and Soliman, 2012, Resnick et al., 2011).
    c. Although it is expected that the report should comment on relevant legal issues examiners must accept that it is not their role to decide on the ultimate issues, and therefore cannot insist that the court follow their opinions.

c. *The report must provide recommendations for treatment or future management*. The courts rely on this, even though they can reject the recommendations, which sometimes enrages examiners. Again, after taking a deep breath, the expert must remind herself that recommendations should be regarded as suggestions and not directives. It is inadvisable to recommend punishments or deprivations, or anything that gratuitously causes harm.

Layout and Language

The forensic report is not a medical report nor an academic treatise. Too frequently forensic reports contain unexplained medical terms and jargon, and worse still, verbatim extracts from DSM with citations and a reference list (Ciccone and Jones, 2011). It's intended readership are professionals who should be regarded as sophisticated laypeople. Therefore, it should be an easy-to-understand narrative, with a discourse and recommendations. Reports do not have to conform to a standardised structure but should follow the guidelines below (Resnick and Soliman, 2012, Gunn et al., 2014).

a. *Use a template*. Templates not only convey the impression that the report is well organized but also can prompt the writer to include all relevant information. A suggested format should have:
    a. *Letterhead*: This should identify the organisation (such as a forensic mental health facility) and identify the author (with her impressive academic credentials). Contact details should also be included.
    b. The examinee's demographic data. Sometimes a case or policy number should also be provided (Kaliski et al., 2006). Remember to provide dates of the writing of the report, and if necessary, dates when the assessment was conducted.
    c. *The referring agent with a statement of the legal issues considered*. No forensic report should have been conducted following vague requests[6]. The courts refer examinees under particular sections of legislation, whereas in civil litigation the referring agent must give an unambiguous

6 Not uncommonly a lawyer will contact the Forensic MHP with the instruction to assess his client "to see if he is mentally ok". The retort should be "OK for what?".

request.

d. *Sources of information*: Occasionally the absence of an important source can be included. Some authors list the interviews, with dates and duration apparently to confer gravitas.
e. *A longitudinal history that leads to the circumstances before, during and after the index legal issue*. A recommendation is to use the well-known Maudsley scheme, but in an abbreviated relevant form.
f. *Mental state examination*: This usually refers to the examinee's mental state during the evaluation. Opinion on the examinee's mental state in the past can be discussed in the Opinion/ Discussion section.
g. *Diagnosis (or diagnoses)*
h. *Opinion and Discussion*
i. *Recommendations*

b. *Length:* Ideally the report should be no longer than 6-8 pages (Ciccone and Jones, 2011). Additional information, such as test scores and investigations, can be inserted in an appendix. Examiners should resist the temptation to write the next great Russian novel because there are 2 types of lawyers who will have to read it. The first type has a poor attention span and consequently will ignore the text and just read the conclusions and recommendations. The second type examines overwritten text intently to find countless points to torment the examiner during a future cross-examination.

c. *Language and appearance*: Resnick et al. (2011) advise that the report should use a 12 pt font with at least 1 ½ line spacing and numbered pages. They then recommend that:
   a. Plain language that uses few technical terms or acronyms[7], which, if used, should be defined or explained. Avoid long sentences and words. In other words, do not be verbose and overly formal.
   b. There are many stock phrases or expressions that can be used repeatedly, because they save time.
   c. Use the active voice and write in the past tense.
   d. Try not to use "hedge words" such as "apparently", "possibly", "reportedly", "supposedly", and definitely not "I think".
   e. Pejorative and denigrating language should never be used.
   f. Do not inject yourself into the report (Kaliski et al., 2006). For example, do not express personal surprise, disbelief or anger regarding the information.

Conclusion

While compiling a forensic report always consider how the intended recipient will read and interpret it. As each piece of data is added try to imagine how you would explain and justify it if cross-examined. Even when experience eventually leads to a facility in writing never lose the fear of being cross-examined.

7 Occasionally writers use legal terms, possibly to impress. But the likelihood that she may not fully understand the import of these can make her vulnerable during cross-examination.

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